MONTANA
Department of Public Health & Human Services

Provider Requirements

Provider Enrollment

To be eligible for enrollment, a provider must:

- Provide proof of licensure, certification, accreditation or registration according to Montana state laws and regulations.
- Provide a W-9.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.

Providers must complete a *Montana Medicaid Provider Enrollment Form*, which is a contract between the provider and the Department. Each provider is assigned a Montana Medicaid provider number, which should be used in all correspondence with Medicaid. Providers must apply for a Medicaid ID number for each type of service they provide. For example, a pharmacy that also sells durable medical equipment (DME) must apply for a Medicaid ID for the pharmacy and another ID for DME. To enroll as a Montana Medicaid provider, visit the Provider Information website or contact Provider Relations (see *Key Contacts*).

Medicaid payment is made only to enrolled providers.

Enrollment materials

Each newly enrolled provider is sent an enrollment letter with the new Medicaid provider number and instructions for obtaining additional information from the Provider Information website.

Most Medicaid-related forms are available in the provider manuals and on the Provider Information website. To order additional forms, complete and mail or fax the order sheet located in *Appendix C: Forms*. We do not provide CMS-1500, UB-92, or dental claim forms.

Medicaid renewal

For continued Medicaid participation, providers must maintain a valid license or certificate. For Montana providers, licensure or certification is automatically verified and enrollment renewed each year. If licensure or certification cannot be confirmed, the provider will be contacted. Out-of-state providers will be notified when Medicaid enrollment is about to expire. To renew enrollment, mail or fax a copy of your license or certificate to the Provider Relations Unit (see *Key Contacts*).

Out-of-state providers can avoid denials and late payments by renewing Medicaid enrollment early.

To avoid payment delays, notify Provider Enrollment of an address change in advance.

Changes in enrollment

Any changes in address, phone number, name, ownership, legal status, tax identification number, or licensure must be submitted in writing to the Provider Relations Unit (see *Key Contacts*). Faxes are not accepted because the provider's original signature and provider number are required. For change of address, you can use the form in *Appendix C: Forms*, and you must include a W-9 form. The Postal Service cannot forward government-issued warrants (checks).

Change of ownership

When ownership changes, the new owner must apply for a new Montana Medicaid number. For income tax reporting purposes, it is necessary to notify Provider Relations at least 30 days in advance about any changes that cause a change in your tax identification number. Early notification helps avoid payment delays and claim denials.

Electronic claims submission

Providers who submit claims electronically experience fewer errors and quicker payment. Providers who are using any of the following electronic claims submission methods must enroll with the ACS EDI Gateway clearinghouse (see *Key Contacts*). All Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an X12N 837 transaction, but does not accept an X12N 835 transaction back from the Department.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12N 837 format using a dial-up connection. Electronic submitters are required to certify their X12N 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the X12N 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact ACS EDI Gateway or Provider Relations (see *Key Contacts*).

Terminating Medicaid enrollment

Medicaid enrollment may be terminated at any time by writing to the Provider Relations Unit. Include your provider number and the termination date in the letter. The Department may also terminate your enrollment under the following circumstances:

- Breaches of the provider agreement
- Demonstrated inability to perform under the terms of the provider agreement
- Failure to abide by applicable Montana and U.S. laws
- Failure to abide by the regulations and policies of the U.S. Department of Health and Human Services or the Montana Medicaid program

Authorized Signature (ARM 37.85.406)

All correspondence and claim forms submitted to Medicaid must have a Medicaid provider number and an authorized signature. The signature may belong to the provider, billing clerk, or office personnel, and may be typed, stamped, computer generated or signed. When a signature is from someone other than the provider, that person must have written authority to bind and represent the provider for this purpose. Changes in enrollment information require the provider's original signature.

Provider Rights

- Providers have the right to end participation in Medicaid at any time.
- Providers may bill Medicaid clients for cost sharing (ARM 37.85.406)
- Providers may bill Medicaid clients for services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services.
    - When the provider does not accept the client as a Medicaid client, it is sufficient for the provider to use a routine agreement to inform the client that he or she is not accepted as a Medicaid client, and that the client agrees to be financially responsible for the services received.
    - When the client has been accepted as a Medicaid client, but the services are not covered by Medicaid, the services can be billed to the client only after the provider has informed the client in writing (before providing the service) that those services are not covered by Medicaid, and the client has agreed to pay for the specific services on a private-pay basis. In this case, a routine agreement will not suffice. (ARM 37.85.406) For more information on billing Medicaid clients, see *Billing Procedures* in the specific provider manual.
- Providers have the right to choose Medicaid clients, subject to the conditions in *Accepting Medicaid clients* later in this chapter.

- Providers have the right to request administrative reviews and fair hearings for a Department action that adversely affects the provider's rights or the client's eligibility. (ARM 37.85.411)

Administrative Reviews and Fair Hearings (ARM 37.5.310)

If a provider believes the Department has made a decision that fails to comply with applicable laws, regulations, rules or policies, the provider may request an administrative review. To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department (see *Key Contacts* or the list of program policy contacts in the *Introduction* chapter of this manual). The Department must receive the request within 30 days from the date the Department's contested determination was mailed. Providers may request extensions in writing within this 30 days.

If the provider is not satisfied with the administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. This document must be signed and received by the Fair Hearings Office (see *Key Contacts*) within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered (or mailed) to the division that issued the determination within three working days of filing the request.

Provider Requirements

By signing the application to enroll in Montana Medicaid, providers agree to abide by the conditions of participation according to ARM 37.85.401. This section discusses some of those conditions; see the application for additional details and precise wording.

Accepting Medicaid clients (ARM 37.85.406)

Institutional providers, eyeglass providers, and non-emergency transportation providers may not limit the number of Medicaid clients they will serve. Institutional providers include nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, hospitals, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities.

Other providers may limit the number of Medicaid clients. They may also stop serving private-pay clients who become eligible for Medicaid. Any such decisions must follow these principles:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- Clients enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- When a provider arranges ancillary services for their Medicaid client through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly. See ARM 37.85.406 (d) for details.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective (see *Client Eligibility and Responsibilities*, *Retroactive Eligibility* for details).
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.
- Once a client has been accepted as a Medicaid client, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

Non-discrimination (ARM 37.85.402)

Providers may not discriminate in the provision of service to Medicaid clients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age, or disability. Providers shall comply with the Department of Health and Human Services regulations under Title VI and Title IX of the Civil Rights Act, Public Law 92-112 (Section 504 and 505) and the Montana Human Rights Act, Title 49, Chapter 2, MCA, and Americans with Disabilities Act as amended and all requirements imposed by or pursuant to the regulations.

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Client must be enrolled in Medicaid and non-restricted (see *Client Eligibility and Responsibilities* for restrictions). (ARM 37.85.415 and 37.85.205)
- Service must be medically necessary. (ARM 37.85.410) The Department may review medical necessity at any time before or after payment.

- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.82.102, 37.85.207, and 37.86.104)
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the *Billing Procedures* chapter of each manual, the most current provider notices and manual replacement pages, and according to ARM 37.85.406 (Billing, reimbursement, claims processing and payment) and ARM 37.85.407 (Third Party Liability).
- Charges must be usual and customary. (ARM 37.85.212 and 37.85.406)
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties ($75.00) is greater than the Medicaid fee ($70.00), Medicaid will pay at $0. (ARM 37.85.406)
- Claims must meet timely filing requirements (see *Billing Procedures* in the specific provider manual for timely filing requirements). (ARM 37.85.406)
- Prior authorization requirements must be met. (ARM 37.85.406)
- PASSPORT approval requirements must be met. (ARM 37.86.5101 - 37.86.5112)

Medicaid payment is payment in full (ARM 37.85.406)

Providers must accept Medicaid payment as payment in full for any covered service, except applicable cost sharing that should be charged to the client.

Payment return (ARM 37.85.406)

If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

Disclosure

- Providers are required to fully disclose ownership and control information when requested by the Department. (ARM 37.85.402)
- Providers are required to make all medical records available to the Department. (ARM 37.85.410 and 37.85.414)

Client services

- All services must be made a part of the medical record. (ARM 37.85.414)
- Providers must treat Medicaid clients and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by regulations). (ARM 37.85.402)

- Providers may not deny services to a client because the client is unable to pay cost sharing fees. (ARM 37.85.402)

Confidentiality (ARM 37.85.414)

All Medicaid client and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of health care information subject to applicable laws.

Record keeping (ARM 37.85.414)

Providers must maintain all Medicaid-related medical and financial records for six years and three months following the date of service. The provider must furnish these records to the Department or its designee upon request. The Department or its designees may audit any Medicaid related records and services at any time. Such records may include (but are not limited to) the following:

- Original prescriptions
- Certification of medical necessity
- Treatment plans
- Medical records and service reports including (but not limited to):
- Patient's name and date of birth
- Date and time of service
- Name and title of person performing the service, if other than the billing practitioner
- Chief complaint or reason for each visit
- Pertinent medical history
- Pertinent findings on examination
- Medication, equipment, and/or supplies prescribed or provided
- Description and length of treatment
- Recommendations for additional treatments, procedures, or consultations
- X-rays, tests, and results
- Dental photographs/teeth models
- Plan of treatment and/or care, and outcome
- Specific claims and payments received for services
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid clients

Providers are responsible for keeping informed about applicable laws, regulations, and policies.

- Records and original invoices for items that are prescribed, ordered, or furnished
- Any other related medical or financial data

Compliance with applicable laws, regulations, and policies

All providers must follow all applicable rules of the Department and all applicable state and federal laws, regulations, and policies. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails.

The following are references for some of the rules that apply to Montana Medicaid. The provider manual for each individual program contains rule references specific to that program.

- Title XIX Social Security Act 1901 et seq.
    - 42 U.S.C. 1396 et seq.
- Code of Federal Regulations (CFR)
    - CFR Title 42 - Public Health
- Montana Codes Annotated (MCA)
    - MCA Title 53 - Social Services and Institutions
- Administrative Rules of Montana (ARM)
    - ARM Title 37 - Public Health and Human Services

Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*).

Provider Sanctions (ARM 37.85.501 - 507 and 513)

The Department may withhold a provider's payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies.

Other Programs

This is how the provider requirements apply in Department of Public Health and Human Services (DPHHS or the Department) programs other than Medicaid.

Mental Health Services Plan (MHSP)

To be paid by MHSP, the provider must be enrolled as a Medicaid provider and, in addition, must sign an addendum to the provider enrollment agreement that is specific to MHSP. If a signed addendum is not on file when a claim is submitted to MHSP, payment will be denied until the addendum is received.

Adults enrolled in MHSP can only receive MHSP services from a contracted Mental Health Center. Children may obtain MHSP services from other enrolled licensed practitioners.
All other policies and procedures in this chapter apply to MHSP providers in the same way they apply to Medicaid providers.

Mental health services **for Medicaid clients** are included within the scope of the Medicaid provider agreement and the separate addendum need not be signed.

Children's Health Insurance Plan (CHIP)

For CHIP, the policies and procedures in this chapter apply only to providers of dental services and eyeglasses. Provider Relations for providers of CHIP dental services and eyeglasses is handled by the same DPHHS contractor as for Medicaid. Providers of these services will receive CHIP provider numbers that differ from Medicaid provider numbers they may already have.

For all other services, CHIP provider relations is administered by BlueCross BlueShield of Montana; call (406) 447-8647 in Helena or (800) 447-7828 x8647 statewide.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program

Providers of chemical dependency services must have a state-approved program, and the provider must sign a contract with the Department's Addictive and Mental Disorders Division for delivery of the covered services.